

PEARL DENTAL

NAME: Last First Middle

ADDRESS: Street or P.O. Box # City State Zip Code PHONE NUMBER HOME: WORK:

YOUR E-MAIL ADDRESS:

AGE: YRS	Birthdate: Mo/Day/Year	BIRTHPLACE:	() Married () Unmarried () Separated	SOCIAL SECURITY NO. (# child, parents) DRIVER'S LICENSE NO.
OCCUPATION:	EMPLOYER:	HOW LONG EMPLOYED:	ADDRESS & PHONE NUMBER:	
PERSON RESPONSIBLE FOR BILL: (# married, spouse's name)		AGE:	RELATIONSHIP:	ADDRESS: SOCIAL SECURITY NO. DRIVER'S LICENSE NO.
OCCUPATION:	EMPLOYER:	HOW LONG EMPLOYED:	ADDRESS & PHONE NUMBER:	

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT WORK PHONE

INSURANCE COMPANY NAME GROUP OR UNION NAME GROUP OR LOCAL NUMBER

EMPLOYER'S NAME FULL ADDRESS OF EMPLOYER

GETTING TO KNOW YOU

1. Why did you select our office? _____

2. Whom may we thank for referring you? _____

3. Is another member of your immediate family or a relative a patient in our practice? _____

4. Person to contact for emergency: _____
Phone: _____

5. Is there anything we can do to make you feel more comfortable? _____

6. When was your last dental visit? _____

7. When was the last time you had complete dental x-rays taken? Doctor's name: _____

8. Have you ever had any teeth removed? _____
How long have these teeth been missing? _____
Have these teeth been replaced? _____
How? Bridge Partial Denture Implants

PAYMENT ALTERNATIVES

PLEASE CHECK APPROPRIATE BOX:

- 1. As a special service to you, we offers a cash courtesy if you pay for your entire treatment plan in full, in advance.
- 2. Cash and personal checks are accepted as your treatments are provided.
- 3. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignments of your insurance payment, as a service to you.

This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

- 4. Mastercard or Visa Card and Discover.
- 5. For long term or extended payments, we offer a healthcare financing program, which when you are accepte will allow extended small monthly payments for the treatme service.

MEDICAL HISTORY

1. Have you ever been under the care of a medical doctor during the past two years? Yes No
If yes, for what reason? _____
-
2. Please provide the name, address and telephone number of your physician? _____
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3. Are you having dental problems at this time? Yes No
4. Do your gums bleed at any time? Yes No
5. Have you ever had a bad experience in the dental office? Yes No
6. Have you been a patient in the hospital during the past two years? Yes No
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7. Have you taken any medicine or drugs during the past two years? Yes No
8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by **Penicillin, Aspirin, Codeine, Latex, Food, Iodine or Anesthetics**? Yes No
If yes, for what reason? _____
9. Have you ever had excessive bleeding requiring special treatment? Yes No
10. Check any of the following which you have had or have at present:
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> HIV Positive (AIDS) | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Artificial Joint (Hip/Knee) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Blood Transfusion | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> X-ray or Cobalt Treatment | | |
11. List all medications you are taking at this time: _____
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12. Has your medical doctor ever said you have cancer or a tumor? Yes No
13. Do you have any disease, condition or problem not listed? If so, please list Yes No
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14. How do you feel about the appearance of your teeth? _____
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15. If You Could Change Anything About Your Smile, What Would You Change? _____
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16. WOMEN: Are you pregnant? Yes No If yes, what month are you due? _____
Are you taking birth control pills? Yes No

RISKS INVOLVED IN ANESTHESIA

LOCAL ANESTHESIA Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage and unexpected allergic reactions which could result in heart attack, stroke, brain damage and/or death.

I hereby authorize the doctor to perform any and all form of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE